

		FOR OHF USE					

LL 1

**2003**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2003)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0040071</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>Monroe Pavilion Health/T Ctr</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>1400 West Monroe</u> <u>Chicago</u> <u>60607</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>Cook</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
<b>Telephone Number:</b> <u>(312) 666-4090</u> <b>Fax #</b> <u>(312) 421-0134</u>		<b>Paid Preparer</b> (Signed) _____ (Date) _____ (Print Name and Title) <u>Richard S. Sgarlata, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> <b>Fax #</b> <u>(847) 236-1155</u>	
<b>IDPA ID Number:</b> <u>363961690001</u>		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> 201 S. Grand Avenue East Springfield, IL 62763-0001 <b>Phone #</b> (217) 782-1630	
<b>Date of Initial License for Current Owners:</b> <u>07/01/94</u>			
<b>Type of Ownership:</b>			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Steve Lavenda</u> <b>Telephone Number:</b> <u>(847) 236 - 1111</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/T Ctr# 0040071 Report Period Beginning: 01/01/03 Ending: 12/31/03

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>136</u>	Intermediate (ICF)	<u>136</u>	<u>49,640</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>136</u>	TOTALS	<u>136</u>	<u>49,640</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>46,460</u>	<u>103</u>	<u>1,762</u>	<u>48,325</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>46,460</u>	<u>103</u>	<u>1,762</u>	<u>48,325</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 97.35%

D. How many bed-hold days during this year were paid by Public Aid?

177 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 07/01/94

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 07/01/94 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number  
of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number

Monroe Pavilion Health/T Ctr

# 0040071

Report Period Beginning:

01/01/03

Ending:

12/31/03

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	163,974	12,329	8,280	184,583		184,583		184,583		1
2	Food Purchase		172,844		172,844	(9,074)	163,770	(302)	163,468		2
3	Housekeeping	131,748	32,905		164,653		164,653		164,653		3
4	Laundry		8,422		8,422		8,422		8,422		4
5	Heat and Other Utilities			117,086	117,086		117,086	228	117,314		5
6	Maintenance	68,734	13,136	72,992	154,862		154,862	(7,165)	147,697		6
7	Other (specify):*							(19)	(19)		7
8	<b>TOTAL General Services</b>	364,456	239,636	198,358	802,450	(9,074)	793,376	(7,258)	786,118		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			23,250	23,250		23,250		23,250		9
10	Nursing and Medical Records	1,071,593	53,999	6,978	1,132,570		1,132,570	(44,206)	1,088,364		10
10a	Therapy										10a
11	Activities	80,850	1,596	2,618	85,064		85,064		85,064		11
12	Social Services			3,842	3,842		3,842		3,842		12
13	Nurse Aide Training			1,494	1,494		1,494		1,494		13
14	Program Transportation			500	500		500	1	501		14
15	Other (specify):*							12	12		15
16	<b>TOTAL Health Care and Programs</b>	1,152,443	55,595	38,682	1,246,720		1,246,720	(44,193)	1,202,527		16
	<b>C. General Administration</b>										
17	Administrative	114,920		246,890	361,810		361,810	(203,513)	158,297		17
18	Directors Fees										18
19	Professional Services			92,362	92,362		92,362	(7,598)	84,764		19
20	Dues, Fees, Subscriptions & Promotions			32,421	32,421		32,421	(23,177)	9,244		20
21	Clerical & General Office Expenses	63,421	17,837	114,054	195,312		195,312	(7,453)	187,859		21
22	Employee Benefits & Payroll Taxes			256,613	256,613	9,074	265,687		265,687		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,607	2,607		2,607	(80)	2,527		24
25	Other Admin. Staff Transportation			1,726	1,726		1,726	146	1,872		25
26	Insurance-Prop.Liab.Malpractice			65,260	65,260		65,260	302	65,562		26
27	Other (specify):*							20,796	20,796		27
28	<b>TOTAL General Administration</b>	178,341	17,837	811,933	1,008,111	9,074	1,017,185	(220,577)	796,608		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,695,240	313,068	1,048,973	3,057,281		3,057,281	(272,028)	2,785,253		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name & ID Number Monroe Pavilion Health/T Ctr #0040071 Report Period Beginning: 01/01/03 Ending: 12/31/03

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			66,683	66,683		66,683	73,385	140,068			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,034	22,034		22,034	447,362	469,396			32
33	Real Estate Taxes			97,067	97,067		97,067		97,067			33
34	Rent-Facility & Grounds			815,342	815,342		815,342	(721,540)	93,802			34
35	Rent-Equipment & Vehicles			3,880	3,880		3,880	4,454	8,334			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,005,006	1,005,006		1,005,006	(196,340)	808,666			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers							(43)	(43)			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			74,460	74,460		74,460		74,460			42
43	Other (specify):*	8,813			8,813		8,813	(8,813)				43
44	<b>TOTAL Special Cost Centers</b>	8,813		74,460	83,273		83,273	(8,856)	74,417			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,704,053	313,068	2,128,439	4,145,560		4,145,560	(477,223)	3,668,337			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Monroe Pavilion Health/T Ctr

# 0040071

Report Period Beginning: 01/01/03

Ending: 12/31/03

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	71,624	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(23,256)	21		18
19	Entertainment	(519)	24		19
20	Contributions	(13,300)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(54,000)	21		24
25	Fund Raising, Advertising and Promotional	(3,113)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(505)	20		28
29	Other-Attach Schedule	(89,551)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (112,624)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(364,600)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (364,600)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (477,223)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

0040071  
Report Period Beginning: 01/01/03  
Ending: 12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES			Amount	Reference
1	Illinois Council on LTC - COPE		\$ (1,950)	20
2	Veteran Pharmacy		(5,204)	10
3	Veteran Medical Expense		(4,844)	10
4	Patient Needs		(13,905)	10
5	Patient Clothing		(260)	10
6	Miscellaneous Income - SBC Ameritech		(74)	23
7	Miscellaneous Income - Record Copies		(260)	21
8	Miscellaneous Income - Food Rebates		(298)	42
9	Collection Fees - Prior Period Adjustment		(465)	19
10	Bank Charges		(13,143)	31
11	Public Relations		(5,000)	20
12	2002 Legal Fees		(7,816)	19
13	Marketing Salary		(8,813)	43
14	Marketing		(844)	19
15	Capitalized R&M		(8,206)	86
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				
32				
33				
34				
35				
36				
37				
38				
39				
40				
41				
42				
43				
44				
45				
46				
47				
48				
49				
50				
51				
52				
53				
54				
55				
56				
57				
58				
59				
60				
61				
62				
63				
64				
65				
66				
67				
68				
69				
70				
71				
72				
73				
74				
75				
76				
77				
78				
79				
80				
81				
82				
83				
84				
85				
86				
87				
88				
89				
90				
91				
92				
93				
94				
95				
96				
97				
98				
99				
100				
101	Total		(89,551)	101

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Monroe Pavilion Health/T Ctr

# 0040071

Report Period Beginning:

01/01/03

Ending:

12/31/03

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary													1
2	Food Purchase	(302)											(302)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			228									228	5
6	Maintenance	(8,206)		1,041									(7,165)	6
7	Other (specify):*			(19)									(19)	7
8	<b>TOTAL General Services</b>	<b>(8,508)</b>		<b>1,250</b>									<b>(7,258)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(44,311)		105									(44,206)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation			1									1	14
15	Other (specify):*			12									12	15
16	<b>TOTAL Health Care and Programs</b>	<b>(44,311)</b>		<b>118</b>									<b>(44,193)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			13,629	(215,577)	(1,565)							(203,513)	17
18	Directors Fees													18
19	Professional Services	(8,490)		856		36							(7,598)	19
20	Fees, Subscriptions & Promotions	(23,874)		765		(68)							(23,177)	20
21	Clerical & General Office Expenses	(89,733)		81,772		508							(7,453)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(519)		423		16							(80)	24
25	Other Admin. Staff Transportation			146									146	25
26	Insurance-Prop.Liab.Malpractice			302									302	26
27	Other (specify):*			17,883	1,728	1,185							20,796	27
28	<b>TOTAL General Administration</b>	<b>(122,616)</b>		<b>115,776</b>	<b>(213,849)</b>	<b>112</b>							<b>(220,577)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(175,435)</b>		<b>117,144</b>	<b>(213,849)</b>	<b>112</b>							<b>(272,028)</b>	<b>29</b>





**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 Rent Income	\$ 728,496	Monroe Pavilion Associates	100.00%	\$	(728,496)
2	V	32 Interest Income		Monroe Pavilion Associates	100.00%	\$ 447,843	447,843
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 728,496			\$ 447,843	\$ * (280,653)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Monroe Pavilion Health/T Ctr

# 0040071

Report Period Beginning: 01/01/03

Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	NUCARE SERVICES CORP.	100.00%	\$ 228	\$ 228
16	V	6 REPAIRS AND MAINT.				1,041	1,041
17	V	7 EMPLOYEE BEN. GEN. SERV.				(19)	(19)
18	V	10 NURSING ADMIN.				105	105
19	V	14 PROGRAM TRANSPORTATION				1	1
20	V	15 HEALTHCARE EMPLOYEE BEN.				12	12
21	V	17 ADMINISTRATIVE - NON-OWNER				13,629	13,629
22	V	19 PROFESSIONAL FEES				856	856
23	V	20 FEES SUBSCRIPTIONS				765	765
24	V	21 CLERICAL & GENERAL				81,772	81,772
25	V	24 SEMINARS AND EDUCATION				423	423
26	V	25 ADMIN. STAFF TRAVEL				146	146
27	V	26 INSURANCE				302	302
28	V	27 EMPLOYEE BEN. GEN. ADMIN.				17,883	17,883
29	V	30 DEPRECIATION				1,761	1,761
30	V	32 INTEREST EXPENSE				(475)	(475)
31	V	34 BUILDING RENT				6,956	6,956
32	V	35 EQUIPMENT RENTAL				4,454	4,454
33	V	39 ANCILLARY				(43)	(43)
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 129,797	\$ * 129,797

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Monroe Pavilion Health/T Ctr

# 0040071

Report Period Beginning: 01/01/03

Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 ADMIN. - R. HARTMAN	\$	NUCARE SERVICES CORP.	100.00%	\$ 11,833	\$ 11,833	15
16	V	17 ADMIN. - B. CARR				9,715	9,715	16
17	V	17 ADMIN. - D. HARTMAN				2,539	2,539	17
18	V	17 ADMIN. - E. DICKMAN				226	226	18
19	V							19
20	V	27 EMP. BEN. - R. HARTMAN				1,048	1,048	20
21	V	27 EMP. BEN. - B. CARR				463	463	21
22	V	27 EMP. BEN. - D. HARTMAN				198	198	22
23	V	27 EMP. BEN. - E. DICKMAN				19	19	23
24	V							24
25	V							25
26	V	17 MANAGEMENT FEES	239,890				(239,890)	26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 239,890			\$ 26,041	\$ * (213,849)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Monroe Pavilion Health/T Ctr

# 0040071

Report Period Beginning: 01/01/03

Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 ADMINISTRATIVE	\$	CAREPATH HEALTH NETWORK	100.00%	\$ 5,435	\$ 5,435
16	V	19 PROFESSIONAL FEES				36	36
17	V	20 FEES, SUBSCRIPTIONS				(68)	(68)
18	V	21 CLERICAL AND GENERAL				508	508
19	V	24 SEMINARS				16	16
20	V	27 GEN ADMIN.- EMP. BEN.				1,185	1,185
21	V	32 INTEREST EXPENSE				(6)	(6)
22	V						
23	V						
24	V	17 MANAGEMENT FEES	7,000				(7,000)
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 7,000			\$ 7,106	\$ * 106

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/T Ctr# 0040071Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	22 WORKERS COMPENSATION	\$ 27,124	DIAMOND INSURANCE	40.00%	\$ 27,124	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 27,124			\$ 27,124	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/T Ctr# 0040071Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/T Ctr# 0040071Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/T Ctr# 0040071Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Monroe Pavilion Health/T Ctr# 0040071Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/T Ctr# 0040071Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 7

Facility Name & ID Number Monroe Pavilion Health/T Ctr # 0040071 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Robert Hartman	Owner	Administration	60.75%	See Attached	2.35	4.70%	Alloc Salary	\$ 11,833	17-7	1
2	David Hartman	Relative	Administration	0%	See Attached	0.50	1.04%	Alloc Salary	2,539	17-7	2
3	Barry Carr	Owner	Administration	4.75%	See Attached	2.56	4.27%	Alloc Salary	16,715	17-7	3
4	Eitan Dickman	Relative	Administration	0%	See Attached	0.22	0.51%	Alloc Salary	226	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 31,313		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/T Ctr # 0040071 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/T Ctr# 0040071

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization NUCARE SERVICES CORP.Street Address 6677 N LINCOLN AVENUECity / State / Zip Code LINCOLNWOOD, IL 60712Phone Number ( 847) 933-2600Fax Number ( 847) 933-2601

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5 UTILITIES	AVAIL. CENSUS DAYS	755,108	9	\$ 3,469	\$	49,640	\$ 228	1
2	6 REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	755,108	9	15,840		49,640	1,041	2
3	7 EMPLOYEE BEN. GEN. SERV.	AVAIL. CENSUS DAYS	755,108	9	(289)		49,640	(19)	3
4	10 NURSING ADMIN.	AVAIL. CENSUS DAYS	755,108	9	1,600	1,600	49,640	105	4
5	14 PROGRAM TRANSPORTATION	AVAIL. CENSUS DAYS	755,108	9	19		49,640	1	5
6	15 HEALTHCARE EMPLOYEE BEN.	AVAIL. CENSUS DAYS	755,108	9	180		49,640	12	6
7	17 ADMINISTRATIVE - NON-OWNED	AVAIL. CENSUS DAYS	755,108	9	207,317	202,582	49,640	13,629	7
8	19 PROFESSIONAL FEES	AVAIL. CENSUS DAYS	755,108	9	13,022		49,640	856	8
9	20 FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	755,108	9	11,642		49,640	765	9
10	21 CLERICAL & GENERAL	AVAIL. CENSUS DAYS	755,108	9	1,243,897	1,034,436	49,640	81,772	10
11	24 SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	755,108	9	6,435		49,640	423	11
12	25 ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	755,108	9	2,216		49,640	146	12
13	26 INSURANCE	AVAIL. CENSUS DAYS	755,108	9	4,598		49,640	302	13
14	27 EMPLOYEE BEN. GEN. ADMIN.	AVAIL. CENSUS DAYS	755,108	9	272,029		49,640	17,883	14
15	30 DEPRECIATION	AVAIL. CENSUS DAYS	755,108	9	26,781		49,640	1,761	15
16	32 INTEREST EXPENSE	AVAIL. CENSUS DAYS	755,108	9	(7,220)		49,640	(475)	16
17	34 BUILDING RENT	AVAIL. CENSUS DAYS	755,108	9	105,808		49,640	6,956	17
18	35 EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	755,108	9	67,754		49,640	4,454	18
19	39 ANCILLARY	AVAIL. CENSUS DAYS	755,108	9	(652)	(1,593)	49,640	(43)	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,974,446	\$ 1,236,040		\$ 129,797	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/T Ctr# 0040071

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization NUCARE SERVICES CORP.Street Address 6677 N LINCOLN AVENUECity / State / Zip Code LINCOLNWOOD, IL 60712Phone Number ( 847) 933-2600Fax Number ( 847) 933-2601

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17 ADMIN. - R. HARTMAN	AVG. HOURS WORKED	36	9	180,000	180,000	2	11,833	1
2	17 ADMIN. - B. CARR	AVG. HOURS WORKED	48	9	180,000	180,000	3	9,715	2
3	17 ADMIN. - D. HARTMAN	AVG. HOURS WORKED	8	9	40,623	40,000	1	2,539	3
4	17 ADMIN. - E. DICKMAN	AVG. HOURS WORKED	17	9	17,157	17,000	0	226	4
5									5
6	27 EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED	36	9	15,944		2	1,048	6
7	27 EMP. BEN. - B. CARR	AVG. HOURS WORKED	48	9	8,574		3	463	7
8	27 EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED	8	9	3,170		1	198	8
9	27 EMP. BEN. - E. DICKMAN	AVG. HOURS WORKED	17	9	1,411		0	19	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 446,879	\$ 417,000		\$ 26,041	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/T Ctr# 0040071

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization CAREPATH HEALTH NETWORKStreet Address 6633 N LINCOLN AVENUECity / State / Zip Code LINCOLNWOOD, IL 60712Phone Number ( 888) 707-6700Fax Number ( 847) 679-2150

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17 ADMINISTRATIVE	CARE PATH FEES	339,037	13	\$ 263,221	\$ 263,221	7,000	\$ 5,435	1
2	19 PROFESSIONAL FEES	CARE PATH FEES	339,037	13	1,730		7,000	36	2
3	20 FEES, SUBSCRIPTIONS	CARE PATH FEES	339,037	13	(3,296)		7,000	(68)	3
4	21 CLERICAL AND GENERAL	CARE PATH FEES	339,037	13	24,604		7,000	508	4
5	24 SEMINARS	CARE PATH FEES	339,037	13	784		7,000	16	5
6	27 GEN ADMIN.- EMP. BEN.	CARE PATH FEES	339,037	13	57,412		7,000	1,185	6
7	32 INTEREST EXPENSE	CARE PATH FEES	339,037	13	(286)		7,000	(6)	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 344,169	\$ 263,221		\$ 7,106	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/T Ctr # 0040071 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization DIAMOND INSURANCE  
 Street Address 40 SKOKIE BLVD SUITE 105  
 City / State / Zip Code NORTHBROOK, IL 60062  
 Phone Number (847) 559-1002  
 Fax Number \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	DIRECT ALLOCATION			\$	\$		\$ 27,124	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 27,124	25

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Monroe Pavilion Health/T Ctr # 0040071 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/T Ctr # 0040071 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/T Ctr # 0040071 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/T Ctr# 0040071

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/T Ctr # 0040071 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5	See Supplemental Schedule											5	
	Working Capital												
6	LaSalle Bank		X	Working Capital	Interest Only				07/01/04	Prime+1	22,034	6	
7									Annual			7	
8	See Supplemental Schedule											8	
9	TOTAL Facility Related						\$	\$			\$ 22,034	9	
	B. Non-Facility Related*												
10												10	
11			X	Allocated from Monroe							447,843	11	
12			X	Allocated from NuCare							(481)	12	
13	See Supplemental Schedule											13	
14	TOTAL Non-Facility Related						\$	\$			\$ 447,362	14	
15	TOTALS (line 9+line14)						\$	\$			\$ 469,396	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line #           

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8							\$	\$			\$	8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital											14	
	B. Non-Facility Related*												
15							\$	\$			\$	15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

- \* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT
- \*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

## B. Real Estate Taxes

**NOTES:**

1. Please indicate a negative number by use of brackets ( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

**SEE ACCOUNTANTS' COMPILATION REPORT**



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Monroe Pavilion Health/T Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040071

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>17-17-102-043-0000</u>	<u>Long Term Care Property</u>	\$ <u>76,463.88</u>	\$ <u>76,463.88</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>76,463.88</u></u>	\$ <u><u>76,463.88</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES   X   NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Monroe Pavilion Health/T Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040071

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
2. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
3. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
4. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
5. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
6. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10. <u>                  </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
<b>TOTALS</b>		\$ <u>                    </u>	\$ <u>                    </u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?            YES            NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A.
Square Feet:
45,004

B. General Construction Type:

Exterior
Brick

Frame
Reinforced Concrete

Number of Stories
4

C.
Does the Operating Entity?

☐ (a) Own the Facility
☒ (b) Rent from a Related Organization.
☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.
Does the Operating Entity?

☐ (a) Own the Equipment
☒ (b) Rent equipment from a Related Organization.
☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.
List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F.
Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	39,159	1982	\$ 30,464	1
2					2
3	TOTALS	39,159		\$ 30,464	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Monroe Pavilion Health/T Ctr

# 0040071

Report Period Beginning:

01/01/03

Ending:

12/31/03

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various		1994		13,951		20	358	358	3,325	9
10	Various		1995		13,124		20	657	657	5,687	10
11	Various		1996		19,194		20	961	961	6,902	11
12	Various		1997		32,365		20	1,619	(1,619)	10,550	12
13	Various		1998		50,879		20	2,544	2,544	13,618	13
14	Various		1999		63,549		20	3,179	3,179	14,798	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		2,059,134			79,197	79,197	1,746,215	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		1,567	63		79	16	351	68
69	Financial Statement Depreciation			40,611			(40,611)		69
70	TOTAL (lines 4 thru 69)		\$ 2,253,763	\$ 40,674		\$ 88,594	\$ 44,682	\$ 1,801,446	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

## STATE OF ILLINOIS

Page 12B

Facility Name &amp; ID Number Monroe Pavilion Health/T Ctr

# 0040071

Report Period Beginning:

01/01/03

Ending:

12/31/03

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,253,763	\$ 40,674		\$ 88,594	\$ 47,920	\$ 1,801,446	1
2	600 Gallon Tank	2000	26,300		20	1,315	1,315	5,150	2
3	Controller Wires	2000	2,324		20	116	116	454	3
4	3 Relay Contacts	2000	879		20	44	44	172	4
5	Repair Contact	2000	572		20	29	29	115	5
6	Instl Exterior Light	2000	648		20	32	32	121	6
7	Service Cctv System	2000	1,295		20	65	65	244	7
8	Cctv Sys & Nurse Sys	2000	961		20	48	48	180	8
9	Install 2 Windows	2000	670		20	34	34	124	9
10	Rewire Contact	2000	1,402		20	70	70	263	10
11	Repair Elevator	2000	2,770		20	139	139	509	11
12	Furnish New Packing	2000	512		20	26	26	94	12
13	Replace Wires	2000	555		20	28	28	112	13
14	Replaced Reclaimer	2000	1,453		20	73	73	261	14
15	Door Track Rollers	2000	754		20	38	38	132	15
16	Repl Level Switch	2000	1,515		20	76	76	266	16
17	Furn&Inst Glass & La	2000	1,054		20	53	53	185	17
18	New Tubing For Retur	2000	1,875		20	94	94	313	18
19	200 Gallon Tank	2000	3,045		20	152	152	508	19
20	Ceiling Tile	2000	740		20	37	37	120	20
21	Fire Alarm Plans	2000	2,400		20	120	120	370	21
22	Nurse Call System	2000	502		20	25	25	77	22
23	Door Alarm & Cctv Sv	2000	891		20	45	45	138	23
24	Cctv Monitor	2000	1,066		20	53	53	164	24
25	Temporary Tank & Asp	2000	1,795		20	90	90	315	25
26	Compressor For Walk-	2000	1,270		20	64	64	212	26
27	Diesel Fuel Tank	2000	1,000		20	50	50	200	27
28	Supply Piping	2000	2,067		20	103	103	387	28
29	600 Gal Tank Add'N	2000	2,200		20	110	110	431	29
30	Elevator Repairs	2001	5,924		20	296	296	888	30
31	Kitchen/Bathroom Hrd	2001	661		20	33	33	94	31
32	Bathroom Hardware	2001	665		20	33	33	95	32
33	Elevator Repairs	2001	755		20	38	38	101	33
34	TOTAL (lines 1 thru 33)		\$ 2,324,283	\$ 40,674		\$ 92,123	\$ 51,449	\$ 1,814,241	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**\*\*Improvement type must be detailed in order for the cost report to be considered complete.**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,379,643	\$ 40,674		\$ 95,126	\$ 54,452	\$ 1,820,360	1
2	Cctv	2002	874		20	44	44	44	2
3	Cctv	2002	1,429		20	71	71	71	3
4	Cctv	2002	1,983		20	99	99	99	4
5	Plumbing Per Cap Proj	2002	7,188		20	359	359	539	5
6	Carbon Monoxide Alarm	2003	1,190		20	89	89	89	6
7	Fire Alarm System	2003	143,415		20	11,951	11,951	11,951	7
8	Nurses Station	2003	30,200		20	1,762	1,762	1,762	8
9	Nurses Station	2003	874		20	87	87	87	9
10	Carpet	2003	3,519		20	503	503	503	10
11	Cctv	2003	971		20	97	97	97	11
12	Cctv	2003	1,271		20	127	127	127	12
13	Concrete Work	2003	1,250		20	42	42	42	13
14	Fire Alarm System	2003	981		20	35	35	35	14
15	Front Door Alarm	2003	1,228		20	44	44	44	15
16	Cctv	2003	1,529		20	38	38	38	16
17	Front Door Monitor	2003	1,496		20	36	36	36	17
18	Pump	2003	765		20	38	38	38	18
19	Pipe & Valves	2003	678		20	34	34	34	19
20	Heat Exchanger	2003	1,401		20	70	70	70	20
21	Rewiring	2003	519		20	19	19	19	21
22	Cable	2003	836		20	45	45	45	22
23	Design Fee	2003	750		20	19	19	19	23
24	Latching Alarm System	2003	744		20	28	28	28	24
25	Pump & Motor	2003	700		20	20	20	20	25
26	Cctv	2003	896		20	44	44	44	26
27	Alarm System	2003	990		20	12	12	12	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,587,320	\$ 40,674		\$ 110,839	\$ 70,165	\$ 1,836,253	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 2,587,320	\$ 40,674		\$ 110,839	\$ 70,165	\$ 1,836,253	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,587,320	\$ 40,674		\$ 110,839	\$ 70,165	\$ 1,836,253	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 2,587,320	\$ 40,674		\$ 110,839	\$ 70,165	\$ 1,836,253	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,587,320	\$ 40,674		\$ 110,839	\$ 70,165	\$ 1,836,253	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 2,587,320	\$ 40,674		\$ 110,839	\$ 70,165	\$ 1,836,253	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,587,320	\$ 40,674		\$ 110,839	\$ 70,165	\$ 1,836,253	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 2,587,320	\$ 40,674		\$ 110,839	\$ 70,165	\$ 1,836,253	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,587,320	\$ 40,674		\$ 110,839	\$ 70,165	\$ 1,836,253	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 2,587,320	\$ 40,674		\$ 110,839	\$ 70,165	\$ 1,836,253	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,587,320	\$ 40,674		\$ 110,839	\$ 70,165	\$ 1,836,253	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 2,587,320	\$ 40,674		\$ 110,839	\$ 70,165	\$ 1,836,253	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,587,320	\$ 40,674		\$ 110,839	\$ 70,165	\$ 1,836,253	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 2,587,320	\$ 40,674		\$ 110,839	\$ 70,165	\$ 1,836,253	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,587,320	\$ 40,674		\$ 110,839	\$ 70,165	\$ 1,836,253	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT



XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,059,134	\$		\$ 79,197	\$ 79,197	\$ 1,746,215	70

XI. OWNERSHIP COSTS (continued)  
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	NuCare Allocation			1997	303	8	35	15	7	94	9
10	NuCare Allocation			1998	265	7	35	13	6	72	10
11	NuCare Allocation			1999	372	32	35	19	(13)	82	11
12	NuCare Allocation			2000	452	12	35	23	(11)	78	12
13	NuCare Allocation			2001	175	4	35	9	5	25	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.  
 \*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total  
 SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)	\$ 1,567	\$ 63		\$ 79	\$ (6)	\$ 351		70

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 692,861	\$ 27,381	\$ 28,736	\$ 1,355	10	\$ 170,690	71
72	Current Year Purchases	6,050	305	409	104	10	409	72
73	Fully Depreciated Assets	25,356	83	83		10	25,356	73
74								74
75	TOTALS	\$ 724,267	\$ 27,769	\$ 29,228	\$ 1,459		\$ 196,455	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1991 FORD E150	1994	\$ 2,200	\$	\$	\$	5	\$	76
77										77
78										78
79										79
80	TOTALS			\$ 2,200	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,344,251	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 68,443	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 140,067	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 71,624	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,032,708	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1978		10/16/98	\$ 815,342			3
4	Additions	Allocated from Building Co			(728,496)			4
5		Allocated from NuCare			6,956			5
6								6
7	TOTAL				\$ 93,802			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 8,334 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$ \_\_\_\_\_

13. /2005 \$ \_\_\_\_\_

14. /2006 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input checked="" type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE <u>120</u>	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input checked="" type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE <u>80</u>
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	350	\$	350	
2	Books and Supplies		54		54	
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)		1,093		1,093	
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	1,497	\$	1,497	
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,497			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
**SEE ACCOUNTANTS' COMPILATION REPORT**

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist	N/A	hrs	\$		
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): See Supplemental										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	585,360		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,672		6
7	Other Prepaid Expenses	13,625		7
8	Accounts Receivable (owners or related parties)	628,176		8
9	Other(specify): <a href="#">See Attached Schedule</a>	43,657		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,292,490	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	524,624		15
16	Equipment, at Historical Cost	317,804		16
17	Accumulated Depreciation (book methods)	(447,150)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <a href="#">See Attached Schedule</a>	41,052		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 436,330	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,728,820	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 91,198	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,508		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	176,862		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,171		31
32	Accrued Real Estate Taxes(Sch.IX-B)	100,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	8,465		35
	<b>Other Current Liabilities(specify):</b>			
36	<a href="#">See Attached Schedule</a>	36,266		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 423,470	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<a href="#">See Attached Schedule</a>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 423,470	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,305,350	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,728,820	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)



**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,346,621</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Adjusting Journal Entries - 12/31/02</b>	<b>(4,326)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,342,295</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(36,945)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(36,945)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,305,350</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 4,106,277	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,106,277	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,706	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,706	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Supplemental Schedule	632	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 632	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,108,615	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	802,450	31
32	Health Care	1,246,720	32
33	General Administration	1,008,111	33
	<b>B. Capital Expense</b>		
34	Ownership	1,005,006	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	8,813	35
36	Provider Participation Fee	74,460	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,145,560	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(36,945)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (36,945)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Monroe Pavilion Health/T Ctr**# **0040071**Report Period Beginning: **01/01/03**

Ending:

**12/31/03****XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,909	2,086	\$ 80,802	\$ 38.74	1
2	Assistant Director of Nursing	1,963	2,502	66,475	26.57	2
3	Registered Nurses	3,876	4,465	103,100	23.09	3
4	Licensed Practical Nurses	16,250	17,826	293,491	16.46	4
5	Nurse Aides & Orderlies	39,119	43,333	405,842	9.37	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,917	2,086	31,812	15.25	9
10	Activity Assistants	5,333	6,080	49,038	8.07	10
11	Social Service Workers					11
12	Dietician	1,885	2,086	40,596	19.46	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,165	14,273	123,378	8.64	15
16	Dishwashers					16
17	Maintenance Workers	4,071	4,380	68,734	15.69	17
18	Housekeepers	138,180	15,274	131,748	8.63	18
19	Laundry					19
20	Administrator	2,093	2,246	84,786	37.75	20
21	Assistant Administrator					21
22	Other Administrative	583	583	30,134	51.69	22
23	Office Manager					23
24	Clerical	3,747	4,212	63,421	15.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	6,870	7,271	91,579	12.60	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,872	2,080	30,304	14.57	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	352	352	8,813	25.04	33
34	TOTAL (lines 1 - 33)	243,185	131,135	\$ 1,704,053 *	\$ 12.99	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly Fee	\$ 8,280	01-03	35
36	Medical Director	Monthly Fee	23,250	09-03	36
37	Medical Records Consultant	Monthly Fee	4,128	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly Fee	2,850	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	50	2,618	11-03	44
45	Social Service Consultant	74	3,842	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	123	\$ 44,968		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Monroe Pavilion Health/T Ctr**# **0040071**Report Period Beginning: **01/01/03**Ending: **12/31/03****XIX. SUPPORT SCHEDULES**

<b>A. Administrative Salaries</b>				<b>D. Employee Benefits and Payroll Taxes</b>			<b>F. Dues, Fees, Subscriptions and Promotions</b>	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
Rick Walworth (01/01/03-03/01/03)	Administrator	0	\$ 25,307	Workers' Compensation Insurance	\$	27,124	IDPH License Fee	\$
Brian Celerio (04/01/03-11/18/03)	Administrator	0	47,262	Unemployment Compensation Insurance		8,420	Advertising: Employee Recruitment	332
Wayne Hanik (11/18/03-12/31/03)	Administrator	0	12,217	FICA Taxes		128,965	Health Care Worker Background Check	
Kathy Brander	Dir of Regulatory Mgmt	0	6,859	Employee Health Insurance		38,731	(Indicate # of checks performed _____)	
Ray Dolan	VP of Risk Mgmt	0	2,344	Employee Meals		9,074	Advertising & Promotion	3,113
Rusti Bauman	VP of Medicare Reimb	0	973	Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions	5,931
See Supplemental Schedule			19,958	Chicago Head Tax		3,268	License & Fees	2,284
TOTAL (agree to Schedule V, line 17, col. 1)				Union Health Insurance		29,478	Yellow Page Advertising	505
(List each licensed administrator separately.)			\$ 114,920	Union Pension Benefits		12,634	Public Relations	5,000
<b>B. Administrative - Other</b>				401K Plan		2,546	See Supplemental Schedule	697
Description			Amount	Other Employee Benefits		5,446	Less: Public Relations Expense	(5,000)
NuCare Services			\$ 239,890				Non-allowable advertising	(3,113)
Carepath Health Network			7,000				Yellow page advertising	(505)
				TOTAL (agree to Schedule V, line 22, col.8)	\$	265,686	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 9,244
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 246,890	<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
<b>C. Professional Services</b>							Out-of-State Travel	\$
Vendor/Payee	Type		Amount					
Frost Ruttenberg & Rothblatt	Accounting		\$ 19,981				In-State Travel	
Dan Foley, CPA	Accounting		200					
Personnel Planner, Inc	Unemployment Consulting		1,075					
Purchasing Plus	Purchasing Service		600					
Mckinnon & Strizak	Legal		2,100					
Stone Benjamin & McGuire	Legal		9,673					
Klien Dub & Holleb, LTD	Legal		32,733					
Sachnoff & Weaver, LTD	Legal		395				Seminar Expense	2,088
Myers Miller Standa & Kraus	Legal		1,591				NuCare Allocation	423
Schwartz Cooper Greenberger	Legal		275				CarePath Allocation	16
Morton Cohen	Purchasing Consultant		109					
See Supplemental Schedule			23,630				Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 2,527
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 92,362					

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Monroe Pavilion Health/T Ctr**

STATE OF ILLINOIS

# **0040071**

Report Period Beginning:

**01/01/03**

Ending:

Page 23

**12/31/03**

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report?  
If YES, give association name and amount. II Council on LTC - \$ 7364.40
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 47 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? X YES \_\_\_\_\_ NO \_\_\_\_\_
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO \_\_\_\_\_ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 74,460  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 9,074 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% in 14  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.